



## MaineCare Services

An Office of the  
Department of Health and Human Services

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March 24, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, Office of MaineCare Services

SUBJECT: Final Rule: MaineCare Benefits Manual, 10-144, Chapters II of Section 90- Physician Services, Section 55-Laboratory Services, Section 75-Vision Services, Section 95-Podiatry Services, Section 101-Medical Imaging and Ch III of Section 90 Physician's Services.

This letter gives notice of a final rule: MaineCare Benefits Manual 10-144, Chapters II of Section 90- Physician Services, Section 55-Laboratory Services, Section 75-Vision Services, Section 95-Podiatry Services, Section 101-Medical Imaging and Ch III of Section 90 Physician's Services.

**Chapter II & III of Section 90- Physician Services:** The Department is formally adopting the emergency rule currently in effect that increased MaineCare reimbursement rate for physician services from 53% to 56.94% as of July 1, 2008. No procedure codes are decreased as a result of this rulemaking. The Department is also removing some prior authorization requirements for services such as hyperbaric oxygen therapy, cochlear implants, septoplasty, and skin tag removal. Providers must still follow eligibility criteria for provision of these services and maintain documentation of medical necessity for utilization review purposes.

Additionally, the Department is adopting the removal of the rate of reimbursement for code 99402. The reimbursement for this procedure code is posted on the Department's website, as are other physician fees. Therefore, this procedure code and the rate does not need to be in the rule. Providers can visit the Office of MaineCare's website for the current fee schedule. The fee schedule can be found at [www.maine.gov/bms](http://www.maine.gov/bms).

**Chapter II Section 55-Laboratory Services, Section 75-Vision Services, Section 95-Podiatry Services, Section 101 Medical Imaging:** The Department is adopting language under the "reimbursement" sections to these areas of policy so that for covered services, MaineCare will reimburse the lowest of 53% of 2005 Medicare rates, the provider's usual and customary or the allowed amount of the Medicare Part B carrier. Providers can visit the Office of MaineCare's website for a list of MaineCare covered services and rates. This rule change clarifies what the current rate is; the rate is not being decreased.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, [http://www.maine.gov/dhhs/bms/rules/provider\\_rules\\_policies.htm](http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm) or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

## **Notice of Agency Rule-making Adoption**

**AGENCY:** Department of Health and Human Services, Office of MaineCare Services

**CHAPTER NUMBER AND TITLE:** MaineCare Benefits Manual, 10-144, Chapters II of Section 90-Physician Services, Section 55-Laboratory Services, Section 75-Vision Services, Section 95-Podiatry Services, Section 101-Medical Imaging and Ch III of Section 90 Physician's Services

**ADOPTED RULE NUMBER:**

**CONCISE SUMMARY:** This letter gives notice of a final rule: MaineCare Benefits Manual 10-144, Chapters II of Section 90- Physician Services and Section 55-Laboratory Services, Section 75-Vision Services, Section 95-Podiatry Services, Section 101-Medical Imaging and Ch III of Section 90 Physician's Services. The Department adopts the increase to the MaineCare reimbursement rate for non-hospital based physician services from 53% to 56.94% as of July 1, 2008. Furthermore, the Department is proposing to remove some prior authorization requirements for services including but not limited to hyperbaric oxygen therapy, cochlear implants, circumcision, septoplasty, and skin tag removal.

Finally the Department is adopting changes to Chapter II Section 55-Laboratory Services, Section 75-Vision Services, Section 95-Podiatry Services, Section 101-Medical Imaging. The Department has amended the language under the "reimbursement" sections to these areas of policy to clarify that the increase mentioned above does not apply to these services. MaineCare will reimburse the lowest of 53% of 2005 Medicare rates, the provider's usual and customary or the allowed amount of the Medicare Part B carrier for these services. Providers can visit the Office of MaineCare's website for a list of MaineCare covered services and rates. This rule change clarifies what the current rate is; the rate is not being decreased.

The Department anticipates no impact to small business; however physicians may need to resubmit claims in order to get the higher reimbursement.

See [http://www.maine.gov/bms/rules/provider\\_rules\\_policies.htm](http://www.maine.gov/bms/rules/provider_rules_policies.htm) for rules and related rulemaking documents.

<b>EFFECTIVE DATE:</b>	March 29, 2009
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**10-144 Chapter 101**  
**MAINECARE BENEFITS MANUAL**  
**CHAPTER II**

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<b>SECTION 90</b>	<b>PHYSICIAN SERVICES</b>	<b>ESTABLISHED 10/15/81</b> <b>LAST UPDATED 3/29/09</b>
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**90.01 DEFINITIONS**

**90.01-1 Cosmetic Procedures and Surgery**

Cosmetic procedures and cosmetic surgery are any procedure or surgery done primarily to improve or change appearance without improving the way the body works.

**90.01-2 Elective Surgery**

Elective surgery is surgery that can be scheduled in advance, is not an emergency, and, if delayed, would not result in death or permanent impairment of health.

**90.01-3 Physician services**

Physician services are those services provided by a licensed physician or other qualified servicing provider, within the scope of practice of his or her profession as defined by state or provincial law in the state or province where services are provided, or under the personal supervision of an individual licensed under state or provincial law to practice medicine or osteopathy.

**90.01- Servicing Provider**

The servicing provider is the trained and appropriately licensed professional who actually renders the medical service to a member.

**90.01-5 Supplies and Materials**

Supplies and materials are items provided by the servicing provider, such as sterile trays, drugs, dressings, wadding, and plaster, that may be reimbursed as separate items. Providers must use the appropriate HCPCS code for supplies and materials, and the charges must not exceed the total acquisition costs. MaineCare does not reimburse for shipping, handling, and related costs. Requirements for financial record keeping are detailed in MaineCare Benefits Manual (MBM), Chapter I.

**90.02 ELIGIBILITY FOR CARE**

Individuals must meet financial eligibility as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

**90.03 DURATION OF CARE**

Each MaineCare member is eligible for those medically necessary covered services as set forth below. The Department reserves the right to request additional information to evaluate medical necessity.

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**90.04 COVERED SERVICES**

A covered service is a service for which the Department may make payment. The Department covers those reasonably necessary medical and remedial services that are provided in an appropriate setting and recognized as standard medical care required for the prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary for health and well-being.

The Department will not give additional reimbursement to physicians who are salaried by a hospital for services billed by the hospital and whose payment is included in the hospital cost report for services provided while a member is hospitalized as an inpatient or receiving outpatient services.

When a non-MaineCare provider covers the practice for a MaineCare provider and performs services, MaineCare will only reimburse the MaineCare billing provider. The MaineCare billing provider must maintain adequate records to document the actual servicing provider. The MaineCare billing provider is responsible for reimbursing the non-MaineCare provider.

Providers should direct any questions about coverage of particular services to the Provider Relations Unit prior to provision of the service. Providers should contact the provider relations specialist assigned to their geographic area.

**90.04-1 Anesthesiology Services**

The Department covers anesthesiology services when personally performed by the qualified servicing provider. The services include the following activities:

- A. Pre-operative evaluation;
- B. Anesthetic plan;
- C. Personal participation in the most demanding parts of the anesthesia service, including induction, emergency, and supervision of all personnel associated with delivery of the anesthetic agent;
- D. Observation of the course of the anesthetic procedure at frequent intervals; and
- E. Physical availability of the anesthesiologist in the operating room or delivery room suite.

However, during the performance of the activities described in subparagraphs (C), (D), and (E), the physician shall not be responsible for the care of more than four (4) other patients concurrently, or the service may not be described as being personally performed, and would not be a covered service under this subsection.

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**90.04 COVERED SERVICES (cont.)**

1. Reimbursement of Anesthesiology Services

MaineCare covers anesthesiology services by computing a price based on a basic value for each procedure with time unit values added to administer the procedure. The Department assigns a basic value to specific procedures that require anesthesia. Time required to administer the anesthetic is then billed in fifteen (15) minute units. To bill properly, providers bill fifteen (15) minute units of value for every fifteen (15) minutes required, added to the basic value assigned for the procedure.

Billable anesthesia time starts at the beginning of the administration of the anesthesia and ends when the member is safely placed under customary post-operative supervision. Providers may include the time spent administering regional and local injections and placing catheters and other monitoring devices in billable time for the delivery of the anesthesia services. Providers should bill these procedures separately only when they are performed independently and not in conjunction with an anesthesia service.

2. Requirements for Billing Anesthesia Services

MaineCare requires providers to use the latest Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Technology (CPT) procedure codes when billing for anesthesia services. These codes already have associated values assigned for each procedure and available modifiers to describe unusual situations.

3. Anesthesia for Non-Surgical Services

When billing for anesthesia for all non-surgical diagnostic, medical services, or dental services, providers should bill the appropriate code for the procedure, with the appropriate anesthesia modifier to indicate that anesthesia was provided for a procedure not usually requiring anesthesia.

4. Anesthesia Administered by Operating Surgeon

MaineCare will make no allowance for topical anesthesia, local infiltration, or digital block anesthesia administered by the operating surgeon. When the surgeon provides regional or general anesthesia, the Department will reimburse for the basic anesthesia value without added time units.

5. Anesthesia Administered by Certified Registered Nurse Anesthetists (CRNA)

MaineCare will reimburse anesthesia performed by certified registered nurse anesthetists (CRNAs) at seventy-five percent (75%) of the amount allowed for physician services. Providers should add the appropriate modifier identified in billing instructions.

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**90.04 COVERED SERVICES (cont.)**

**90.04-2 Vision Services**

Ophthalmologic procedures for diseases of the eye are covered when billed with appropriate CPT codes. Vision services must meet the guidelines detailed in MBM, Section 75, Vision Services.

**90.04-3 Laboratory Services**

Allowances for laboratory procedures apply to lab services provided by physicians or by independent laboratories. Providers must be willing to participate in proficiency testing. Tests that produce an index or ratio based on mathematical calculations using two (2) or more separate results may not be billed as separate tests, i.e., A/G ratio, free thyroxine index, etc.

MaineCare reimburses for tests that are frequently done as a group (panel) on automated equipment as a group under a single code in its reimbursement rate. For any combination of these tests, providers must bill the appropriate CPT code that correctly designates the tests included in the panel. MaineCare will reimburse no more than the price of the most appropriate panel for any tests performed individually on the same day.

Please refer to MBM, Chapter II, Section 55, regarding Laboratory Services provided in a physician's office and referrals for laboratory services.

**90.04-4 Obstetrical Services for Pregnant Women**

**A. Provider Qualifications**

MaineCare reimburses for obstetric services provided to a woman who is pregnant only when the provider meets at least one of the following criteria:

- Is board eligible or certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or the appropriate approved specialty board of the American Osteopathic Association;
- Is employed by or affiliated with a federally qualified health center (as defined in §1905(l)(2)(B) of the Act);
- Holds admitting privileges at a hospital participating in an approved MaineCare plan;
- Is a member of the National Health Service Corps; or

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**90.04 COVERED SERVICES (cont.)**

- Documents a current, formal consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in above in Section 90.04-16 (A) for purposes of specialized treatment and admission to a hospital; or
- Is an approved provider of services in a rural health center (RHC), ambulatory care clinic, or is otherwise approved by the Department as a primary care provider (PCP).

**B. Obstetrical Services**

Obstetrical care services include antepartum care, delivery, postpartum care, and other services normally provided in uncomplicated maternity care. Antepartum care includes usual prenatal services (e.g., initial and subsequent history, physical examination, recording of weight, blood pressure, fetal heart tones, maternity counseling, etc.).

Delivery includes management of labor and vaginal delivery (with or without episiotomy, with or without forceps), or cesarean section, and resuscitation of newborn infant when necessary. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, including routine postpartum visits.

MaineCare covers treatment of medical complications of pregnancy (e.g., toxemia, cardiac problems, neurological problems, etc.) or other problems requiring additional or unusual services and requiring hospitalization.

When a non-MaineCare provider covers the practice for a MaineCare provider and performs obstetrical services, MaineCare will only reimburse the MaineCare billing provider. The MaineCare billing provider must maintain adequate records to document the actual servicing provider. The MaineCare billing provider is responsible for reimbursing the non-MaineCare provider.

**C. Reimbursement for Obstetrical Care**

MaineCare provides two methods for maternity care billing, global charge basis or per service charge basis. Physicians may choose only one of the two (2) methods for each delivery as set forth below:

- i. Global charge basis. Several procedure codes are all-inclusive of delivery, antepartum, and postpartum care and can be used to bill one all-inclusive charge following the member's delivery. Providers may not bill a global charge for patients who were not MaineCare eligible during the entire pregnancy.

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**90.04 COVERED SERVICES (cont.)**

Providers may bill total maternity care codes (global charge basis) only in those instances where the provider performs each of the components of maternity care, and only if eight (8) or more visits over a period of at least four (4) months are provided during the antepartum phase of maternity care. Providers may bill maternity related office visits in excess of eleven (11) visits in addition to the global code.

- ii. Per service charge basis. Providers may bill on per service basis for maternity care.

**90.04-5 Psychiatric Services**

MaineCare covers psychiatric services as defined below when provided by or under the direct supervision of a psychiatrist who is board eligible or certified by the American Board of Psychiatry and Neurology; or, American Osteopathic Board of Neurology and Psychiatry as documented by written evidence from such Board; or in the case of Doctors of Medicine; have completed three (3) years of post graduate training in psychiatry approved by the Educational Council of the American Medical Association and having written evidence of such training. Providers practicing in Canadian provinces must meet comparable psychiatry certification guidelines. (Refer to Section 90.04-17 for services provided by other qualified providers.)

**A. Covered Services**

The Department will reimburse for psychiatric outpatient services for up to five (5) services in any consecutive seven (7) day period, except when a member requires services for an emergency situation. An emergency situation is when there is sudden, disordered, or socially inappropriate behavior that requires therapeutic response in order to prevent life threatening or psychologically damaging consequences. MaineCare will reimburse for up to eight (8) emergency therapy visits per emergency, for no more than two (2) hours within a single twenty-four (24) hour period. When the same provider performs two (2) services for the same member on any one day, MaineCare will reimburse for only one (1) service, at the higher payment rate of the two (2) services.

Providers must use appropriate CPT codes when providing psychotherapy services. MaineCare members receiving psychotherapy services under this section of the MaineCare Benefits Manual are ineligible to receive comparable or duplicative services, during the same time period, except as otherwise noted in MBM, Chapter II, Section 14, Advanced Practice Registered Nurse (APRN) Services, Chapter II, Section 45, Hospital Services, Chapter II, Section 65, Behavioral Health Services, or Chapter II, Section 46, Psychiatric Facility Services.

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**90.04 COVERED SERVICES (cont.)**

MaineCare reimburses for the following services:

1. Medication management or drug therapy, defined as the prescription by a physician of psychoactive drugs to favorably influence a present mental illness or to preclude the recurrence of a mental illness, will not be reimbursed as a separate charge if no other psychiatric service is provided; providers should bill medication management as an office visit.
2. Evaluation and Diagnosis is the formulation or evaluation of a treatment plan for the member that includes a direct encounter between the member and the provider.
3. Psychotherapy, both with the individual member and his or her family, is a method of treatment of mental disorders using the interaction between the therapist and a member or a family member in an individual or group setting to promote emotional or psychological change to alleviate mental disorder. Family therapy sessions without the member being present are allowed if the purpose of the family therapy session is to address goals in the member's individual treatment plan

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Providers must keep clinical records that include, but are not limited to: the member's name, address, attending physician, other providers, and the member's history, diagnosis, and treatment plan, treatment documentation, and any discharge/ closing summaries. The provider of the therapy service shall sign all entries.

4. Electro-shock Treatment i.e., the administration of a stimulating electric current to the head, affecting the brain cortex and producing a changed level of consciousness of the patient.
5. Inpatient Services, including admission, daily care, and inpatient psychotherapy.

Hospital admission is the initial hospital visit, comprehensive and complete diagnostic history and physical examination, preparation of hospital records and initiation of diagnostic and treatment services.

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**90.04 COVERED SERVICES (cont.)**

Daily Care, i.e., is the interval history, examination and treatment of members in an inpatient hospital setting. MaineCare will reimburse for as many inpatient hospital visits per week as are medically necessary.

Providers must include a personalized plan of care in the medical record that itemizes the type of psychiatric services needed, how the service can best be delivered, short and long-range goals, and a discharge plan.

6. Psychometric Testing for diagnostic purposes to determine the level of intellectual function, personality characteristics, etc., through the use of standardized test instruments. Testing for educational purposes is not a covered service.

Psychometric testing includes the administration of the test, the interpretation of the test, and the preparation of test reports. Providers do not have to include preliminary diagnostic interviews or subsequent consultation visits in the limits or rates for psychological testing.

MaineCare limits reimbursement for psychological testing sessions to no more than four (4) hours for each test, except for the following:

1. Each Halstead-Reitan Battery is limited to no more than seven (7) hours (including testing and assessment). This test is limited to cases where there is a question of a neuropsychological deficit.
2. Testing for intellectual level is limited to no more than two (2) hours for each test.
3. Each self-administered test is limited to thirty (30) minutes.
4. MaineCare limits reimbursement for psychometric testing to a total of four (4) hours.

**90.04-6 Medical Imaging Services**

Chapter II, Section 101, of the MaineCare Benefits Manual further details Medical Imaging Services. Medical Imaging Services are comprised of two parts, A) the professional component, and B) the administrative and technical component, and are reimbursed using a global fee unless standard modifiers are utilized to identify that only one component was provided. Providers must follow HCPCS and CPT guidelines for radiology using appropriate modifiers.

MaineCare does not reimburse for repeat x-ray examinations of the same body part for the same condition required because of technical or professional error in the original x rays.

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**90.04 COVERED SERVICES (cont.)**

**90.04-7 Drugs Administered By Other Than Oral Method in the Office Setting**

Drugs and biologicals must meet all the general requirements for coverage of items as incidental to a physician's services. MaineCare does not cover the dispensing of prescription and nonprescription drugs and biologicals to members.

To be reimbursable, a drug or biological must meet all of the following criteria:

1. The drug or biological cannot be self-administered;
2. It is not an immunization;
3. It is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered; and
4. It has not been determined by the Food and Drug Administration (FDA) to be less than effective.

Physicians must bill following the Department's billing instructions when billing for these codes. Although drugs must have an assigned J-code to be eligible for reimbursement, providers must also indicate National Drug Code (NDC) codes on the claim in order to be reimbursed. MaineCare will not reimburse claims without both a valid J-code and NDC.

MaineCare will not reimburse for physician administered drugs that are not rebateable under Centers for Medicare and Medicaid Services (CMS) regulation unless the physician obtains Prior Authorization (PA). PA procedures can be found in Chapter 1 of the MaineCare Benefits Manual. PA will not be granted for non-rebateable, physician administered drugs for which there are therapeutically equivalent alternatives that are rebateable. Instructions for billing, a crosswalk of J-codes and a list of rebateable NDC codes are available on the Office of MaineCare Services (OMS) website at <http://www.maine.gov/dhhs/bms/provider.htm>. Providers must bill acquisition cost only, excluding shipping and handling.

**90.04-8 Orthopedic Shoes**

MaineCare covers orthopedic shoes when prescribed by a physician, but they may not be billed under physician services. The provision and billing of shoes must comply with the guidelines of MBM, Chapter II, Section 60, Medical Supplies and Durable Medical Equipment.

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**90.04 COVERED SERVICES (cont.)**

**90.04-9 Computerized Axial Tomography (CAT) Scans**

MaineCare reimburses CAT scans of the head and full body. Please refer to Chapter II, Section 101, of the MaineCare Benefits Manual, regarding requirements for Computerized Axial Tomography Scans.

**90.04-10 Medical Supplies & Durable Medical Equipment**

Providers may bill for those supplies needed in performing office procedures that are above and beyond what is usually used in a normal office visit. MaineCare reimburses acquisition cost only, excluding shipping and handling.

MaineCare reimburses for certain medical and durable medical equipment (e.g., essential prosthesis, braces, intermittent positive pressure breathing (IPPB) machines, oxygen, etc.) when prescribed. Physicians providing this equipment must inform members of their freedom of choice to obtain these items from other suppliers. MaineCare shall not reimburse physicians for both prescribing and supplying durable medical equipment to the same member unless the durable medical equipment is otherwise unobtainable or the item typically requires no maintenance or replacement during the period used by a member. If these circumstances do exist, reimbursement to the prescribing physician for also supplying an item shall be on the basis of the reasonable acquisition cost of the item to the physician.

Providers must maintain documentation of acquisition cost, including receipts and a copy of the original invoice, and make such documentation available to the Department upon request. Providers must also maintain documentation supporting the necessity of providing the supplies and/or equipment during the office visit. MaineCare shall not reimburse physicians for on-going medical supplies that are obtained through providers enrolled as Medical Supplies and Durable Medical Equipment Providers.

**90.04-12 Reimbursement for Services of Interns, Residents, and Locum Tenens**

MaineCare does not reimburse for services of interns and residents provided in a hospital or hospital affiliated facility or physician's office when the cost of the services of interns and residents is included in hospital reimbursement. Residents, locum tenens and temporaries must enroll as servicing providers under a physician's practice in order for their services to be reimbursed by MaineCare.

**90.04-12 Insurance Coverage - Service Benefit**

When a member is covered by insurance with a service benefit principle, the insurance payment is considered payment in full in accordance with the service benefit agreement between the physician and the insurance company. MaineCare should not be billed in such instances.

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**90.04-13 Mileage**

Physicians may bill for mileage, one-way, beyond a ten (10) mile radius of point of origin (office or home). MaineCare does not reimburse mileage for trips to a hospital, nursing facility, ICF, or residential care facility where the physician is an active member of the medical staff or where the physician has ownership.

**90.04-14 Preventive Services**

MaineCare reimburses for preventive and routine physical examinations for children and adults. Physicians must complete the appropriate rider to the MaineCare Provider/Supplier Agreement to participate in preventive health services. Providers must also follow specific guidelines for preventive services.

MaineCare does not cover physical exams performed solely for the purpose of school, sports, disability benefits, life or health insurance coverage, Workers' Compensation, the Driver Education and Evaluation Program (DEEP), work, or any other reason not related to medical necessity.

Except when medically contra-indicated, immunization(s) must be given at time of examination(s) as appropriate for age and health history.

MaineCare covers the following preventive services:

**A. Preventive Health: Children and Adults:**

MaineCare reimburses certain preventive services when using the following guidelines:

**1. For Children:**

MaineCare covers initial, inter-periodic and periodic screening, diagnosis, and treatment services (formerly called EPSDT) for children and young adults up to the age of twenty-one (21) when performed in accordance with the Bright Futures Guidelines for Preventive Child Health Supervision. Physicians must complete a rider to the MaineCare Provider/ Supplier Agreement, perform exams according to these guidelines, and submit the completed Bright Futures Assessment Form. Physicians must also comply with Chapter II, Section 94, Prevention, Health Promotion, and Optional Treatment Services for Members Under Age twenty-one (21).

**2. For Adults:**

MaineCare covers initial and periodic comprehensive health histories and examinations for adults age twenty-one (21) and older. The frequency of

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routine physicals for adults must not exceed one time per twelve (12)-month period. Covered screening services include, but are not limited to, those recommended by the United States Preventive Service Task Force. Physicians should bill the preventive medicine evaluation and management procedure codes.

**90.04-15 Physician Services for Children Under Age Twenty-one**

MaineCare reimbursement is available for physician services provided to a child under age twenty-one (21) only when the provider meets at least one of the following criteria:

- A. Is board eligible or certified in family practice, pediatrics, or internal medicine by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or the appropriate approved specialty board of the American Osteopathic Association;
- B. Is employed by or affiliated with a federally qualified health center as defined in §1905(l)(2)(B) of the Act;
- C. Holds admitting privileges at a hospital participating in MaineCare;
- D. Is a member of the National Health Service Corps;
- E. Documents a current, formal consultation and referral arrangement with a pediatrician or family practitioner who has the certification described above in Section 90.04-15 (A) for purposes of specialized treatment and admission to a hospital; or
- F. Is an approved provider of services in a rural health center (RHC), ambulatory care clinic, or is otherwise approved as a provider under MBM, Chapter II, Section 94, Prevention, Health Promotion, and Optional Treatment Services for Members Under Age Twenty-one (21).

**90.04-16 Services by Other Providers in Association with Physician Services**

When employed in a physician's practice, services provided by the following professionals practicing within the scope of their certification and licensure are reimbursable:

- Advanced Practice Registered Nurse (APRN);
- Audiologist;
- Certified Clinical Nurse Specialist (CNS);
- Certified Nurse Midwife (CNM);
- Certified Nurse Practitioner (NP);

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- Certified Registered Nurse Anesthetist (CRNA);
- Licensed Clinical Professional Counselor (LCPC);
- Licensed Clinical Social Worker (LCSW);
- Licensed Master Social Worker (LMSW);
- Licensed Professional Counselor (LPC);
- Nurse Practitioner (NP);
- Occupational Therapist (OT);
- Physician's Assistant (PA);
- Physical Therapist (PT);
- Registered Nurse First Assist (RNFA).

The following criteria must be met prior to reimbursement of these services:

- A. The servicing provider must be enrolled with MaineCare as a servicing provider within the physician's practice, and must bill in accordance with MaineCare and HCFA 1500 billing instructions;
- B. The servicing provider must be providing services within the scope of practice of his or her license;
- C. The servicing provider must be licensed to practice in accordance with current laws and regulations in the state or province in which he or she is practicing;
- D. The services must be provided under the delegation or supervision of a MaineCare enrolled physician licensed under state or provincial law to practice medicine or osteopathy. The responsible supervising physician shall be available at all times for consultation with all servicing providers identified in Section 90.04-17. MaineCare does not cover supervision of servicing providers. Consultation may occur in person, by telephone or by some other appropriate means consistent with instant communication.

Servicing providers must be an integral part of the physician's practice, and must be based within the setting/facility.

- E. Audiologists practicing under a physician's supervision and billing under physician's services are also subject to the provisions found in MBM Chapter II, Section 109, when billing in accordance with MBM, Chapter III, Section 90.
- F. When offering psychiatric services under the supervision of a physician, other qualified providers, as noted above, must be supervised by a physician who is specialized in the practice of psychiatry, as detailed in Section 90.04-5. Psychiatric services covered under this Section may be provided in an individual, family, or group setting.

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**90.04-17 Interpreter Services**

Please see MBM Chapter 1, Section 1.06-3 for the requirements for Interpreter services.

**90.04-18 Team Conferences**

MaineCare covers face-to-face medical conferences by a physician or servicing provider with an interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care when the member is not present.

MaineCare does not cover conferences between staff of the same clinic or agency or team conferences by telephone.

**90.04-19 Tobacco Cessation**

MaineCare covers the following services when they are performed under the direct care or supervision of a physician and in accordance with the following requirements:

MaineCare covers counseling and treatment for tobacco dependence to educate and assist members with smoking cessation. Services may be provided in the form of brief individualized behavioral therapy, which must be documented in the medical record. Providers must educate members about the risks of smoking, the benefits of quitting and assess the member's willingness and readiness to quit. Providers should identify barriers to cessation, provide support, and use techniques to enhance motivation for each member. Providers may also use pharmacotherapy for those members for whom it is clinically appropriate and who are assessed as willing and ready to quit, or in the process of quitting.

Providers may bill these services alone or in addition to other outpatient evaluation/management services provided on the same date of service. MaineCare only reimburses separately for these additional services when used for the express purpose of counseling and/or risk factor reduction directed at tobacco addiction, and only when used in conjunction with an appropriate tobacco use disorder documented in the medical record. MaineCare limits covered services to three (3) sessions per member, per calendar year, per provider.

**90.04-20 Prescriptions**

Any prescriber who has an individual DEA number must use that identifier when writing prescriptions, rather than a number assigned to an institution.

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**90.04-21 Independent Procedures**

Providers may not bill separately for services commonly carried out as an integral part of a total service (e.g.: dipstick urinalysis). However providers may bill separately for independent service not immediately related to other services.

**90.04-22 Consultation and Referral**

MaineCare distinguishes a consultation from a referral. A consultation includes services rendered by a physician whose opinion or advice is requested by another provider for the further evaluation and or management of the member.

If the consulting physician assumes responsibility for the continuing care of the member, any subsequent services rendered by this physician are not considered to be consultation.

A referral is the transfer of the total or specific care of a member from one provider to another.

**90.04-23 Immunizations, Therapeutic Injections, and Hyposensitization**

When provided as part of an examination and/or treatment, MaineCare will reimburse for the services described below in addition to the office visit. However, when the only service provided is immunization, therapeutic injection, or hyposensitization the rate is all-inclusive.

- a. Immunizations: Immunization codes include both administration of and the immunological material. Providers should report the size of the dose administered when billing for immunizations. To be reimbursed for the immunological materials, providers must bill only the acquisition cost of the serum, excluding shipping and handling, plus the appropriate code for administration of the immunization. MaineCare does not cover documentation of immunizations.

MaineCare only reimburses for the materials used for oral or intra-nasal immunizations, without an administration fee.

1. Vaccines Distributed by the State of Maine Center for Disease Control and Prevention (formerly Bureau of Health) Immunization Program:

Providers should bill for administration of vaccines distributed by the Bureau of Health in accordance with Office of MaineCare Services billing instructions.

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Providers administering immunizations to children ages birth through age eighteen (18) years of age, must participate in the Vaccines for Children (VFC) program. Providers would like more information or would like to enroll in the VFC program should contact the Maine Center for Disease Control and Prevention's Immunization Program or visit their website at: [http://www.maine.gov/dhhs/boh/ddc/\\_immunization/](http://www.maine.gov/dhhs/boh/ddc/_immunization/)

Providers should direct any questions about the administration of State supplied vaccines to the Maine Center for Disease Control and Prevention.

**2. Vaccines Not Distributed by the Maine Center for Disease Control and Prevention:**

When not supplied by the Maine Center for Disease Control and Prevention, providers should bill therapeutic injections and immunizations using the proper NDC code. The charged amount for the therapeutic and immunological material must reflect the acquisition cost of the material to the provider. Providers must keep copies of invoices in their files. Any vaccine that could be obtained by distribution from the Maine Center for Disease Control and Prevention is not reimbursable, e.g., Measles, Mumps and Rubella (MMR).

MaineCare will only reimburse the provider fee for the administration of such a vaccine.

- b. Therapeutic injections: Providers should consult MaineCare billing instructions to bill therapeutic injections using the proper code for the type of injection delivered. The charged amount for the therapeutic material must reflect the acquisition cost of the material to the provider.
- c. Hyposensitization: Hyposensitization codes include allergy sensitivity testing only; the allergenic extract is billed separately.

**90.04-24 Prepaid Kits Purchased From the Maine Center for Disease Control and Prevention, Health and Environmental Testing Laboratory**

The Maine Center for Disease Control and Prevention, Health and Environmental Testing Laboratory has specimen kits available for use in submitting certain

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specimens to the State laboratory for analysis. Providers must purchase these kits from the State laboratory. When a provider uses a kit to collect a specimen from a MaineCare member, providers should notify the State laboratory of the name and MaineCare ID number of the member for whom the kit was used. The State laboratory will then bill the kit to MaineCare. A replacement kit will be sent to the provider.

**90.04-25 Surgical Services**

**a. General Information**

Allowances for surgery include payment for the following (all-inclusive) services:

1. Pre-operative visits in the hospital;
2. The surgery itself (including anesthesia that is not regional or general); and
3. Normal follow-up care for thirty (30) days following the surgery, regardless of treatment setting.

**b. Post-Operative Treatment**

In most cases, MaineCare does not pay additionally for post-operative treatment. Exceptions may be made under the following circumstances:

1. There are complications requiring additional or unusual services may be allowed. The claim will be manually reviewed.
2. The allowances for diagnostic procedures include the procedure and the follow-up care related to the recovery from the procedure itself. Care related to the condition diagnosed as a result of the procedure is not included and may be billed separately.

**c. CPT Coding for Common Situations**

MaineCare requires use of standard CPT codes and modifiers. Providers should consult current CPT and HCPCS publications for these modifiers. The following are examples of situations that often arise in regard to surgical procedures. Special CPT modifiers may be required for these situations:

1. **Additional Surgical Procedures:** When an additional surgical procedure is carried out within the thirty (30) day follow-up period for a previous surgery, the follow-up periods will continue concurrently to their normal termination. (e.g.: surgery done on 9/1/02, thirty (30) day follow-up period through

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10/1/02; subsequent surgery done on 9/12/02, thirty (30) day follow-up period through 10/12/02.)

2. Incidental Procedures: Certain procedures are commonly carried out as an integral part of a total service and are not covered separately. When an incidental procedure (e.g. incidental appendectomy, lysis of adhesions, excision of scar, puncture of ovarian cyst) is performed through the same incision, the allowance will be for the major procedure only.
3. Independent Procedures: No allowance will be made for services listed in CPT coding as "independent procedures" when they are carried out as a part of a total service. However, when such a procedure is carried out as a separate entity, not immediately related to other services, the procedure will be covered. (e.g.: cystoscopy in conjunction with bladder surgery does not warrant additional payment; cystoscopy in conjunction with hysterectomy is an independent procedure .)
4. Multiple Surgical Procedures: When multiple or bilateral surgical procedures are performed at the same operative setting and add significant time or complexity to patient care, the total reimbursement equals the allowance for the major procedure plus fifty percent (50%) of the allowance for the lesser procedure(s).
5. Assistance at Surgery: MaineCare will reimburse for a physician as a surgical assistant (including physician's assistants and Registered Nurse First Assists) for major surgery at twenty percent (20%) of the surgical allowance. Providers should use the appropriate modifier code when reporting a surgical assist.
6. Co-Surgeons: When the skills of two (2) physicians are required to perform the procedure, providers may allocate the allowance according to the responsibility and work done. The physicians must make the Department aware of the allowance distribution.
7. Surgical Team: Allowances for surgery performed under the surgical team concept will be determined on a "By Report" basis.

**90.04-26 Oral and TMJ Surgery Billed with CPT codes**

Providers of oral and temporomandibular joint (TMJ) surgery must also comply with all applicable rules of MBM, Chapter II and III, Section 25, Dental Services, including but not limited to urgent care guidelines and prior authorization. All TMJ surgeries require prior authorization.

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**90.04-27 Chiropractic Services**

Chiropractic services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 15, Chiropractic Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

**90.04-28 Occupational Therapy Services**

Occupational therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 68, Occupational Therapy Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

**90.04-29 Physical Therapy Services**

Physical therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 85, Physical Therapy Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

**90.04-30 Speech Therapy Services**

Speech therapy services must be performed as detailed in MaineCare Benefits Manual, Chapter II, Section 105, Speech and Hearing Services. Providers should also see instructions for documenting rehabilitation potential in Section 90.05-3.

**90.04-31 Topical Fluoride Varnish**

Therapeutic application of topical fluoride varnish is covered for members under the age of twenty-one (21) with moderate to high caries risk. MaineCare will cover application two (2) times per calendar year. For members with high caries rates or new restoration within eighteen (18) months, as are documented in the member's record, MaineCare will cover up to three (3) applications per calendar year. Coverage is allowable for physicians with subspecialties of general or family practice, preventative medicine, pediatric, or internal medicine.

**90.05 RESTRICTED SERVICES**

**90.05-1 Services Covered With Prior Authorization (PA)**

Some services and procedures require prior authorization for MaineCare to provide payment. MaineCare lists physician procedures, the amount paid for the service, and whether the procedure requires prior authorization on the Office of MaineCare Services website. When new procedure codes are added to MaineCare reimbursement, MaineCare may requires prior authorization. Only some of the

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categories of procedures requiring prior authorization are detailed in this section; providers are responsible for checking each procedure code on the OMS website to determine whether it is covered and whether it requires prior authorization.

Procedures requiring PA are at:

[http://portalxw.bisoex.state.me.us/oms/proc/pub\\_proc.asp?cf=mm](http://portalxw.bisoex.state.me.us/oms/proc/pub_proc.asp?cf=mm). Providers should contact the MaineCare Prior Authorization Unit for more information on the prior authorization process.

MaineCare covers the following services only when the Department has granted prior authorization:

**A. Breast Reconstruction**

MaineCare only covers breast reconstruction with prior authorization, and only covers the procedure after cancer surgery or trauma.

**B. Breast Reduction and Mastopexy**

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Breast reduction and mastopexy require prior authorization and documentation of medical necessity. The request for prior authorization must be submitted by the surgeon performing the surgery. These procedures are not covered for cosmetic purposes only. Members must meet symptom severity of criteria one or two (1 or 2) below, and all of the criteria three through six (3-6). Members under the age of twenty-one (21) or forty (40) years of age or older must meet additional criteria, as described below.

Documentation required for prior authorization includes all of the following:

- 1) Member has persistent symptoms in at least two (2) of the anatomical body areas below, affecting daily activities for at least one (1) year:
  - a) pain in upper back;
  - b) pain in neck;
  - c) pain in shoulders;
  - d) headaches;
  - e) painful kyphosis or scoliosis documented by x rays;
  - f) pain, discomfort or ulceration from bra straps cutting into shoulders; or
- 2) Recurrent or chronic dermatitis, intertrigo, or ulceration in the infra-mammary area in and of itself are rarely most medically and cost effectively with reduction mammoplasty.

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If prior authorization is sought due to the presence of these conditions, there must be evidence from medical progress notes from at least three (3) distinct visits over at least six (6) months. The visits must document the specific recommendations given to the member as well as, for the follow-up visits, the degree of compliance with the recommended measures in order to document that the measures are truly unsuccessful versus inadequately trialed. Trial treatments include, but are not limited to, dermatological treatments such as antibiotics or antifungal therapy, attempts to improve skin hygiene such as drying measures including powders, avoiding irritants, moisturizers, adequate nutrition and attempts to improve the situation with supportive garments.

**And**, all of the following criteria must be met:

- 3) Photographic documentation confirming severe breast hypertrophy, and shoulder grooving; and
- 4) Documentation of an evaluation by a doctor other than the one performing the surgery who has determined that all of the following criteria are met:
  - i. The macromastia is the likely cause of the member's symptoms; and
  - ii. The symptoms are likely to be improved with the reduction mammoplasty; and
  - iii. Pain symptoms are documented by a physician or related provider to have persisted despite at least a three (3) month trial of at least two (2) of the following groups of therapeutic measures:
    - a. Supportive devices (e.g., proper bra support, wide bra straps);
    - b. Analgesics, non-steroidal anti-inflammatory drugs (NSAIDs), or other pain medications;
    - c. Physical therapy, exercises, posturing maneuvers; and supervised weight loss.
- 5) An opinion from the surgeon estimating that at least three hundred (300) grams of breast tissue, not fatty tissue, will be removed or at least the following minimum formula, based on the member's body surface area (BSA):  $(BSA (m^2) = ([height (cm) \times weight (kg)] / 3600)^{1/2})$ :

Body Surface Area (m <sup>2</sup> )	Weight of tissue removed per breast (grams)
1.40	324.3
1.41	330
1.42	335
1.43	340

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<b>Body Surface Area (m<sup>2</sup>)</b>	<b>Weight of tissue removed per breast (grams)</b>
1.44	350
1.45	355
1.46	360
1.47	365
1.48	375
1.49	380
1.50	385
1.51	395
1.52	400
1.53	405
1.54	415
1.55	420
1.56	430
1.57	435
1.58	445
1.59	455
1.60	460
1.61	470
1.62	480
1.63	485
1.64	495
1.65	505
1.66	510
1.67	520
1.68	530
1.69	540
1.70	550
1.71	560
1.72	570
1.73	580
1.74	590
1.75	600
1.76	610
1.77	620
1.78	635
1.79	645
1.80	655
1.81	665
1.82	680
1.83	690
1.84	705
1.85	715
1.86	730
1.87	740
1.88	755

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<b>Body Surface Area (m<sup>2</sup>)</b>	<b>Weight of tissue removed per breast (grams)</b>
1.89	770
1.90	780
1.91	795
1.92	810
1.93	825
1.94	840
1.95	855
1.96	870
1.97	885
1.98	900
1.99	915
2.00	935
2.01	950
2.02	965
2.03	985
2.04 or higher	At least 1000

- 6) And for members under the age of twenty-one (21), all of these additional criteria must be met:
  - a) Second surgical opinion in support of the procedure from a surgeon in a practice not affiliated with the first surgeon; and
  - b) Counseling with a mental health professional to document the member's understanding of the indications, alternatives, and life long ramifications of this surgery or
  - c) consultation with another primary care provider.
- 7) And members forty (40) years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty.

**C. Bunion Surgery**

All bunion surgery must be prior authorized. MaineCare only covers bunion surgeries where risk exists for significant foot damage if not repaired, or for pain severe enough to affect ambulation. Members must be functionally ambulatory. Inability to find comfortable shoes is not sufficient for coverage of surgery. The Department will use the following criteria for prior authorization:

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- 1) When necessary due to underlying illness or severity of the condition, such that progressive harm would occur without the procedure. Examples of such conditions are peripheral vascular disease, diabetes, or neuropathy of the foot causing pressure ulcers that, due to the extent of the deformity, have failed to improve after an appropriate trial of custom-made shoes; or
- 2) For the diagnosis of pain only after the provider documents pain that is ongoing or recurrent despite a ninety (90) day trial of an appropriately fitted orthosis, shoe, or change of footwear; and trial of at least one (1) other treatment including non-steroidal anti-inflammatory drugs or acetaminophen, or physical therapy. In addition, a weight bearing x-ray must have been performed in the previous six (6) months (to the date of the PA request) documenting: an intermetatarsal angle (IMA) formed by the long axis of the first and second metatarsals) of twelve (12) degrees or greater; **and** a hallux valgus angle (HVA) of thirty (30) degrees or greater; or
- 3) Documented recurrent bursitis; or
- 4) A neuroma secondary to the bunion; or
- 5) Demonstration of osteoarthritis on x-ray, as evidenced by any of the following:
  - a. mild to moderate bony proliferative pathology; or
  - b. loss of the cartilage space between the bones; or
  - c. cysts in the metatarsal head.

For members under the age of twenty-one (21), the opinion of a second surgeon not affiliated with the first surgeon's practice is required, with documentation submitted along with the prior approval request.

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**D. Gastric Bypass, Gastroplasty Surgery or Adjustable Gastric Banding**

Reimbursement will be made to the physician, hospital or other health care provider for services related to gastric bypass, gastroplasty surgery or adjustable gastric banding only when prior approval has been granted by the Department. The request for prior authorization must be submitted by the surgeon who will be performing the surgery. Approval will be granted only when the physician requesting prior authorization can clearly document in writing the following conditions:

1. The patient's weight is at least twice the normal weight, or one hundred (100) lbs. over the ideal weight;

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2. The patient has been unable to obtain the desired weight loss through non-surgical means under appropriate medical supervision, including psychological evaluation
3. There is an appropriate pre-operative, post-operative, and follow-up plan by the physician and dietitian; and
4. The surgery is medically necessary to correct an illness or condition caused by or aggravated by the obesity, such as diabetes or hypertension.
5. For members under the age of twenty-one (21), the surgery must also be recommended by all of the following, with documentation submitted with the prior approval request:
  - a. a primary care provider;
  - b. an endocrinologist;
  - c. a second surgeon not affiliated with the first surgeon's practices; and
  - d. a licensed mental health professional specializing in children's mental health.

**E. Orthognathic Surgery**

Orthognathic surgery requires prior authorization, and is not covered for cosmetic purposes. Orthognathic surgery is only covered for medically necessary indications such as:

1. Jaw and craniofacial deformities causing significant functional impairment for the following clinical indications:
  - a. repair or correction of a congenital anomaly that is present at birth; or
  - b. restoration and repair of function following treatment for a significant accidental injury, infection, or tumor.
2. Anteroposterior, vertical, or transverse discrepancies or asymmetries that are two or more standard deviations from published norms and that cause one or more of the following documented functional conditions:
  - a. difficulty swallowing and/or choking, or ability to chew only soft or liquid food for at least four (4) months; or
  - b. speech abnormalities determined by a speech pathologist or therapist; or

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- c. malnutrition related to the inability to masticate, documented significant weight loss over four (4) months and a low serum albumin related to malnutrition; or
- d. intra-oral trauma while chewing related to malocclusion; or
- e. significant obstructive sleep apnea not responsive to treatment.

Documentation must include, but is not limited to, study models with appropriate bite registration, intra-oral and extra-oral photographs, and cephalometric x-ray.

**L. Out-of-State Services**

All services, including but not limited to diagnosis, evaluation or treatment to be provided outside the State of Maine require prior authorization. (See MaineCare Benefits Manual, Chapter I, Section 1.17 for policies and procedures regarding out-of-state services). Use of out-of-state diagnostic services, excluding lab or radiology tests by enrolled MaineCare providers, requires prior authorization. MaineCare providers referring out-of-state services are responsible for assuring that services are referred to a MaineCare provider. Providers cannot bill the member unless the member was advised at the physician's office prior to provision of the service that the service may not be covered by MaineCare and that the member may be responsible for the services. Prior notification must be documented in the member's record.

**M. Removal of Excess Skin and Subcutaneous Tissue of Abdomen**

Removal of excess skin and subcutaneous tissue of the abdomen (panniculectomy) requires prior authorization. MaineCare will only cover this procedure when at least one (1) year has passed since bariatric surgery, or the provider clearly documents at least one hundred (100) pounds of weight loss (between pre-operative evaluation and current weight, if appropriate), recorded at office visits, and documentation that the pannus hangs at least to the pubis as documented by photographs.

A physician other than the operating surgeon must document one (1) of the following:

- a) A medical condition that is likely due to the pannus such as intractable intertrigo, dermatitis, or ulceration persistent despite at least ninety (90) days of conservative therapy documented by at least three (3) office visits over the last ninety (90) days. Providers must document specific instructions given for appropriate skin hygiene and/or

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treatment and also must document the degree of self-reported member compliance so as to clearly document the failure of the less conservative measures and an adequate trial of these therapies; or

- b) Significant obstruction of ambulation.

For members under the age of twenty-one (21), supporting opinion of a second surgeon not affiliated with the first surgeon is required, with documentation submitted along with the prior approval request.

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**N. Podiatry Services**

All podiatry services are subject to requirements in MBM, Chapter II, Section 95, and many podiatric procedures require prior authorization.

**O. Vagus Nerve Stimulation**

MaineCare covers medically necessary vagus nerve stimulation for treatment of partial onset seizures for adults and children over twelve (12) years of age when clinically appropriate medications are refractory.

**90.05-2 Services Covered When Special Criteria Are Met**

MaineCare covers the services described below when performed in accordance with the following criteria:

**A. Abortion Services**

In compliance with PL 103-112, the Health and Human Services Appropriations bill, reimbursement for abortion services will be made only if necessary to save the life of the mother, or if the pregnancy is the result of an act of rape or incest.

Abortion services are covered only when performed in a licensed general hospital or outpatient setting, and when the following conditions are met:

1. A physician has found, and so certified in writing to the Department, that on the basis of his/her professional judgment an abortion is necessary to save the life of the mother; or the pregnancy is the result of an act of rape; or the pregnancy is the result of an act of incest.
2. If the abortion is performed in order to save the life of the member, the certification must contain written justification as to the necessity of the abortion procedure.

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3. The certification must contain the name and address of the member.
4. The member's medical record shall be documented as to the circumstances of the abortion procedure.

A sample letter of certification is shown below:

I, \_\_\_\_\_ (Name of physician), certify that on the basis of my professional judgment, an abortion is necessary for \_\_\_\_\_ (name of member) of \_\_\_\_\_ (member's address) for the following reason(s): (Check all that apply)

- ☐ in order to save the member's life.
- ☐ the pregnancy is the result of an act of rape.
- ☐ the pregnancy is the result of an act of incest.

Present justification as to the necessity of an abortion performed in order to save the life of the member. (Attach supporting information, as necessary.)

\_\_\_\_\_  
(Signature of Physician)

\_\_\_\_\_  
(Date)

The physician's certification must be submitted to the Department. The member's medical record is not required for submission, however, it must be available for review by the Department, upon request.

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In compliance with federal requirements, the Department will reimburse for the procedure if the treating physician certifies that in his or her professional opinion, the member was unable for physical or psychological reasons to comply with established reporting requirements, if any, in cases of rape or incest.

Although no payment can be made until the provider submits all required documentation to the Department, the provider should provide necessary medical services immediately as needed.

**B. Sterilization Procedures and Hysterectomies**

MaineCare will reimburse for sterilization procedures and hysterectomies only when all of the conditions spelled out below are met in order to comply with 42 CFR 441.250 through 441.259 of the Code of Federal Regulations.

**1. Definitions for the Purpose of This Section**

- a. Sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing, and can apply to both men and women.
- b. Hysterectomy means a medical procedure or operation for the purpose of removing the uterus.
- c. Institutionalized Individual means an individual who is (A) involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or (B) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
- d. Mentally Incompetent Individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

**2. Sterilization Procedures**

Reimbursement for sterilization procedures will be made only if they are performed in accordance with the following criteria:

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- a. The individual to be sterilized is:
  - i. At least twenty-one (21) years of age at the time the consent for sterilization is obtained.
  - ii. Not considered a "Mentally Incompetent Individual" as defined in 90.05-2(D) above.
  - iii. Not an "Institutionalized Individual" as defined in 90.05-2. C above.
  - iv. Not in labor or childbirth when the consent to be sterilized is obtained.
  - v. Not seeking to obtain or obtaining an abortion when the consent to be sterilized is obtained.
  - vi. Not under the influence of alcohol or other substances that affect the individual's state of awareness when the consent to be sterilized is obtained.
- b. The individual must have given voluntary Informed Consent in accordance with the following conditions:
  - i. The individual who is blind, deaf or otherwise handicapped must be provided the same information as defined below through any suitable arrangements that ensure it is effectively communicated.
  - ii. When necessary, an interpreter is provided to insure that the member understands the language used on the consent form and by the provider obtaining consent.
  - iii. The member to be sterilized must be permitted to have a witness present when the consent is obtained.
  - iv. The provider who obtained the informed consent offered to answer any questions the member may have concerning the procedure.
  - v. The member to be sterilized was provided a copy of the consent form and orally given the following information or advice:
    - a. that he/she is free to withhold or withdraw consent to the procedure at any time;

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- b. that his/her choice to withhold or withdraw consent will not affect the right to future care or treatment; and
    - c. that he/she may withhold or withdraw consent at any time, and will not lose any benefits from any federally funded benefits for which the individual is eligible.
  - vi. The member is provided with a description of alternative methods of family planning and birth control.
  - vii. The member is advised that the procedure is considered irreversible.
  - viii. The member is provided with a thorough explanation of the specific procedure to be performed.
  - ix. The member is told of any and all discomforts and risks that may accompany or follow the performing of the procedure.
  - x. The member is given a full description of the benefits or advantages that may be expected as a result of the procedure.
  - xi. The member is advised that the procedure will not be performed for at least thirty days, except in the case of emergency abdominal surgery or premature delivery.
- c. A properly completed consent form, as defined below, is provided to the Department. To be acceptable it must meet the conditions as follow:
  - i. The consent form must be the one furnished by the federal government or an exact copy. A member may consent to be sterilized at the time of emergency abdominal surgery if at least seventy-two hours have passed since the member gave informed consent for the sterilization.

A member may consent to be sterilized at the time of a premature delivery if at least seventy-two hours (72) has passed since the member gave informed consent for the sterilization and the informed consent was obtained at least thirty (30) days before the expected delivery date.
  - ii. The form is completed at least thirty (30) days but no more than one hundred eighty (180) days prior to the date of the sterilization procedure. (The only exception to this requirement is i above.)

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- iii. The form is signed and dated by:
  - a. The member to be sterilized;
  - b. The interpreter, if applicable;
  - c. The provider who obtained the consent; and
  - d. The physician who performed the sterilization.
- iv. Copies of the signed consent form are to be distributed as follows;
  - a. One (1) copy to the member to be sterilized;
  - b. One (1) copy to be retained by the physician; and
  - c. One (1) copy forwarded to the OMS with the usual billing invoice.

**Sterilization Consent Form**

A properly completed consent form must be attached to the billing invoices. If it is necessary to send the consent form in separately, please send it to:

MaineCare Prior Authorization Unit  
Office of MaineCare Services  
11 State House Station  
Augusta, Maine 04333- 0011

Additional copies of the consent form are available upon request from the unit named at the above address.

**3. Sterilization Pamphlets**

Two approved pamphlets containing required information on sterilization are available. They are entitled "Information for Women" and "Information for Men." Copies may be obtained from the Family Planning Association of Maine, 43 Gabriel Drive, Augusta, Maine 04330 or The National Clearinghouse for Family Planning Information, PO 2225, Rockville, Maryland 20852.

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**4. Hysterectomy**

In accordance with Federal regulations (42 CFR 441.255 and 441.256) payment for a hysterectomy and related services may be made from MaineCare funds only when specific criteria are met.

- a. MaineCare will not reimburse for hysterectomy when the procedure would not have been performed except to render an individual permanently incapable of reproducing.
- b. MaineCare will only reimburse procedures performed in accordance with the following criteria:
  - i. The provider who secured the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing.
  - ii. The individual and her representative, if any, were provided information orally and in writing about the procedures.
  - iii. The individual or her representative, if any, has signed a written informed consent with acknowledgment of receipt of the information referred to in (a) and (b) above prior to the individual having the procedures.

The "Hysterectomy Information Form" (BMS-045), which meets federal requirements, is available to meet this informed consent requirement. Documentation submitted in lieu of the above informed consent form, which contains all required information as shown on the BMS-045 is acceptable.

- c. The member or her representative must sign and date the consent form.

One (1) copy of the informed consent form is to be given to the member, one (1) copy is to be retained by the physician or hospital, and one (1) copy is to be forwarded to MaineCare with the usual billing invoice.

The only exceptions to the above requirements are:

- i. The member was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the member was already sterile at the time of the hysterectomy, and states the cause of sterility.

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- ii. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that informed consent is not possible, and certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior informed consent was not possible. The physician must also include a description of the nature of the emergency.
- iii. Hysterectomies performed during a period of a member's retroactive MaineCare eligibility if the physician who performed the hysterectomy certifies in writing that:
  - a. The member was informed before the operation that the hysterectomy would make her permanently incapable of reproducing, or
  - b. One of the conditions in Chapter II, Section 90.05(2)(D) (1) and (2) was met. The physician must supply the written information specified in Chapter II, Section 90.05-2 (C) (1) and (2) of this manual.

If it is necessary to submit the hysterectomy Informed Consent form separately please send it to:  
MaineCare Authorization Unit  
Office of MaineCare Services  
11 State House Station  
Augusta, Maine 04333-0011

Additional copies of the "Hysterectomy Information Form" (BMS-045) are available upon request from the unit named at the above address.

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**C. Circumcision**

Circumcision for cosmetic or routine purposes is not covered.

These criteria apply to all members: Documentation must outline conservative therapies tried for at least ninety (90) days, and the failure of these measures. Therapies to be tried include, when appropriate, behavioral and topical therapies. If no conservative therapy is medically appropriate, none is required.

The record must clearly document the medical condition for which the circumcision was performed and, when appropriate, conservative therapies tried and failed as outlined above. If the record is inadequate to document that the circumcision was not performed for cosmetic, routine, or ritual purposes,

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the procedure may be determined to not be medically necessary and per, Chapter I of the MBM, payments may be recouped.

**D. Cochlear Implants**

All cochlear implants must meet the following criteria:

1. The member has a diagnosis of bilateral severe-to-profound sensorineural hearing impairment that has been treated with little or no benefit from appropriate hearing (or vibrotactile) amplification; and
2. The member has the cognitive ability to use age-appropriate auditory cues, and the member, directly or through a parent/guardian, has the capacity and willingness to undergo an extended course of rehabilitation; and
3. The member is free from middle ear infection; has accessible cochlear lumen that is structurally suited to implantation; and is free from lesions in the auditory nerve and acoustic areas of the central nervous system; and
4. There are no contraindications to surgery; and
5. The device is in accordance with FDA-approved labeling.
6. In addition to criteria 1-5 above, the following criteria must also be met

For children ages one (1) through seventeen (17):

MaineCare covers cochlear implants for prelinguistically and postlinguistically deafened children over the age of one (1). For children ages twelve (12) months through twenty-three (23) months providers must demonstrate bilateral profound sensorineural hearing loss and lack of progress in the development of auditory skills with hearing aid(s) or other amplification. For children ages twenty-four (24) months to seventeen (17) years, providers must demonstrate bilateral severe-to-profound hearing loss and lack of progress in the development of auditory skills with hearing aid(s) or other amplification.

7. In addition to criteria 1-5 above, the following criteria must be met for adults (age eighteen (18) and older):

MaineCare covers cochlear implants for prelinguistically, perilinguistically, and postlinguistically deafened adults. Providers must demonstrate little or no benefit from hearing aids, defined as speech recognition scores of less than

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fifty percent (50%) on sentence level testing in the ear to be implanted and less than sixty percent (60%) in the non-implanted ear or in the binaural condition.

**E. Cosmetic Procedures**

MaineCare does not cover medical or surgical procedures performed solely for cosmetic purposes. Examples of potentially cosmetic procedures include, but are not limited to abrasion of skin or lesion, chemical peel or salabrasion, and cervicoplasty. Some procedures that are potentially cosmetic procedures are covered when done to correct deformities resulting from cancer, disease, trauma, or birth defects. All procedures that may be performed for cosmetic reasons require documentation of medical indication in the medical record for utilization review purposes.

**F. Hyperbaric Oxygen Therapy**

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

**1. Covered Conditions** - Reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one person unit) for the following conditions:

- a. Acute carbon monoxide intoxication;
- b. Decompression illness;
- c. Gas embolism;
- d. Gas gangrene;
- e. Acute traumatic peripheral ischemia therapy used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- f. Crush injuries and suturing of severed limbs as an adjunctive treatment when loss of function, limb, or life is threatened);
- g. Progressive necrotizing infections (necrotizing fasciitis);
- h. Acute peripheral arterial insufficiency;
- i. Preparation and preservation of compromised skin grafts (not for primary management of wounds);

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- j. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;
- k. Osteoradionecrosis as an adjunct to conventional treatment;
- l. Soft tissue radionecrosis as an adjunct to conventional treatment;
- m. Cyanide poisoning;
- n. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment;
- o. Diabetic wounds of the lower extremities in patients who meet all of the following three (3) criteria:
  - i. Member has type I or II diabetes and has a lower extremity wound that is due to diabetes;
  - ii. Member has a wound classified as Wagner grade III or higher; and
  - iii. Member has failed an adequate course of standard wound therapy.

The use of HBO therapy for diabetic wounds is covered as adjunctive therapy only after there are no measurable signs of healing for at least thirty (30)–days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in members with diabetic wounds includes: assessment of a member’s vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least thirty (30) consecutive days. Wounds must be evaluated at least every thirty (30) days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any thirty (30)-day period of treatment.

- 2. **Noncovered Conditions** – MaineCare will not reimburse HBO in the treatment of the following conditions:
  - a. Cutaneous, decubitus and stasis ulcers;

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- b. Chronic peripheral vascular insufficiency;
- c. Anaerobic septicemia and infection other than clostridial;
- d. Skin burns (thermal);
- e. Senility;
- f. Myocardial infarction;
- g. Cardiogenic shock;
- h. Sickle cell anemia;
- i. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency;
- j. Acute or chronic cerebral vascular insufficiency;
- k. Hepatic necrosis;
- l. Aerobic septicemia;
- m. Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, and Korsakoff's disease);
- n. Tetanus;
- o. Systemic aerobic infection;
- p. Organ transplantation;
- q. Organ storage;
- r. Pulmonary emphysema;
- s. Exceptional blood loss or anemia;
- t. Multiple sclerosis;
- u. Arthritic diseases; or
- v. Acute cerebral edema; or
- w. All other indications not listed as covered conditions above.

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3. Reasonable Utilization Parameters - Payment will only be made where HBO therapy is clinically practical. HBO therapy should not be a replacement for other standard successful therapeutic measures. Depending on the response of the individual member and the severity of the original problem, treatment may range from less than one (1) week to several months duration, the average being two (2) to four (4) weeks. The medical necessity for use of hyperbaric oxygen must be documented in the medical record for utilization review purposes.
4. Topical Application of Oxygen- This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no MaineCare reimbursement may be made for the topical application of oxygen.

**G. Infertility Services**

Infertility services, including evaluation and treatment, are not covered by MaineCare. Treatments and procedures that are usually performed for the sole purpose of evaluation or treatment of infertility require utilization review to document medical necessity of the procedure for reasons other than the treatment of infertility.

**H. Penile Implants**

Penile implants, including insertion, repair, or replacement will only be covered after surgery for cancer, trauma, or birth defect where pharmacologic treatments have failed.

**I. Rhinoplasty**

MaineCare does not cover these surgeries for cosmetic purposes. Medical necessity must be documented to show that symptomatic, ongoing, or recurrent breathing obstructions or infections are present despite at least a sixty (60) day trial of conservative treatment.

**J. Skin Tag Removal**

MaineCare will only cover skin tag removal when there is significant, ongoing, or recurrent irritation or discomfort that is documented in the medical record.

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**90.05-3 Services Covered When Rehabilitation Potential Is Documented**

Some MaineCare services that are not routinely performed by a physician nevertheless require documentation by a physician of medical necessity or rehabilitation potential. These services include, but are not limited to, chiropractic services, home health services, physical therapy, occupation therapy, or speech therapy services.

For services requiring documentation of rehabilitation potential, providers should include diagnosis or complaint, how member was assessed, (e.g. by phone, exam, therapist evaluation) why rehabilitation potential is expected, (e.g. acute condition, acute exacerbation of chronic condition, past response to therapy, etc.) and indicators of measurable functional improvement. Other providers may, if requested by the physician, use an evaluation to assist the physician in determining the member's rehabilitation potential. In the case of a service requiring recent surgery to obtain prior authorization, such as in the case of chiropractic services, surgery must have been performed within the previous sixty (60) days (to the PA request).

**90.06 SERVICES FOR MEMBERS IN DIFFERENT SETTINGS**

**90.06-1 Nursing Facilities and Other Group Care**

**A. Nursing Facility Admissions**

The admission of a member to a nursing facility under the MaineCare program requires prior approval from the Department of Health and Human Services. Approval for admission is given only when a member meets the medical eligibility requirements for nursing facility services, as set forth in Chapter II, Section 67 of the MaineCare Benefits Manual, and when adequate alternate arrangements cannot be made for home or community based care. NF applicants must receive a medical eligibility assessment with the Department's approved assessment instrument (see Section 67).

**B. On-Going Nursing Facility Care**

When the physician continues to serve as the attending physician to members after they enter a nursing facility, or accepts as new patients members who are receiving care in a nursing facility, he or she is expected to provide, at a minimum, those physician services that are required, by Federal regulations and by the State of Maine Regulations Covering the Licensing and Functioning of Nursing Facilities, to be provided in licensed MaineCare approved facilities.

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**C. Documentation in Member's Chart**

All services provided to members in group care facilities by the physician or servicing provider are to be documented by the provider in the member's chart maintained in the facility. All orders to be carried out by facility staff are to be signed by the physician or servicing provider. A rubber stamp of the signature is not considered adequate.

**D. Referrals by Attending Physician**

Professional services in a group care facility are only covered when ordered by the attending physician or the servicing provider working under his/her supervision.

**E. Physicians with Facility Ownership**

No charges may be made for services provided to members in a group care facility by a physician or servicing provider in a physician's practice who derives a direct or indirect profit from ownership of the facility, except for emergency services provided for acute illness.

**90.06-2 Outpatient Hospital Services**

**A. Referrals**

A physician or servicing provider may refer members for essential services such as laboratory tests, x-ray examination, etc., that are provided by a hospital on an outpatient basis.

**B. Emergency Services**

Emergency services are those services provided to persons requiring immediate care in the emergency room of the hospital, necessitated by unforeseen conditions such as injury, accident or sudden illness.

Charges may be made by a physician who personally attends a member in the emergency room providing he or she is not salaried by the hospital or whose salary is or associated with a group of physicians with a financial contract to provide emergency room care.

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**90.06-3 Inpatient Hospital Services**

A physician may admit a member for essential inpatient hospital services in connection with covered treatment of an illness or injury. The facility's patient care coordinator monitors the medical need for hospital admission and the length of the hospitalization. There are limitations on the length of stay according to the specific needs of the individual member for hospital care. The Department will only make payment for days certified by the patient care coordinator. MaineCare will deny payment of additional physician services provided during the non-certified hospitalization.

**Exception:** The Department will reimburse for physician services rendered from date of admission to the first review date even if the patient care coordinator denies the admission.

**90.07 NON-COVERED SERVICES**

When MaineCare does not cover specific procedures, all services related to that procedure are not covered, including physician, facility, and anesthesia services. Services that are not reimbursable by MaineCare include, but are not limited to:

**A. Cosmetic Surgery**

Surgeries that are performed solely for cosmetic reasons are not covered by MaineCare. MaineCare defines cosmetic surgery as any surgery done primarily to improve or change appearance without improving the way the body works. Procedures that may potentially performed for either cosmetic or medical reasons require prior authorization documenting the medical indication for the procedure. MaineCare does cover some potentially cosmetic procedures when done to correct deformities resulting from cancer, disease, trauma, or birth defects, as detailed in Section 90.05. Examples of non-covered cosmetic surgery are:

1. Circumcision, which is usually a cosmetic procedure, is not covered unless medically necessary. Circumcision that is routine or cosmetic including routine newborn circumcision is not covered. Circumcision for preventative, social, ethnic, or religious reasons, regardless of age, is not covered. MaineCare covers some circumcisions with an appropriate medical indication.
2. Piercings and removal of tattoos;

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**B. Infertility Services**

Treatments and procedures solely for the purpose of evaluation or treatment of infertility are not covered. In addition, MaineCare does not cover reversal of sterilization.

**C. Other Non-Covered Services**

1. Garren-Edwards Gastric Bubble;
2. Acupuncture;
3. Medical care provided by mail, telephone or internet;
4. Autopsy examinations;
5. Preparation and duplication of records, forms, and reports;
6. Hypnosis;
7. Reversal of sterilization procedures;
8. Transsexual procedures; and

Any service described in 90.04-1 that exceeds the stated restrictions.

**90.08 POLICIES AND PROCEDURES**

The following policies and procedures supplement the general information within this section:

**90.08-1 Medical Record Requirements**

Each provider shall maintain financial and professional records of sufficient quality to fully and accurately document the nature, scope, and details of the health care provided. Providers shall provide copies of financial and professional records to the Department in the form and manner requested without charge to the Department or the member. Chapter I details the five (5) year requirement for maintaining records.

- A. Physicians must maintain one office medical record for each member even in group practices, partnerships, and other shared practices. Providers must document specific services rendered in chronological order. Chapter I provides additional requirements for record-keeping.

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The medical records corresponding to office, home, nursing facility, hospital, outpatient and emergency room services billed to the Department must include but shall not be limited to:

1. Date of each service ordered and provided;
2. Member's name, name of responsible person (if different from the member, e.g., parent or guardian), date of birth, and MaineCare ID number;
3. Name and title of provider performing the service if it is other than the billing physician;
4. Medical history/ including member's health condition;
5. Pertinent findings on examination;
6. Medications administered or prescribed, when applicable;
7. Description of treatment, when applicable;
8. Recommendations for additional treatments or consultations;
9. Medical goals;
10. Supplies dispensed or prescribed (if any); and
11. Tests and results; and
12. Dated provider signature.

**B. Record Requirements for Psychotherapy Services**

In addition to the above medical record requirements, when psychotherapy services are provided, a personalized plan of care must be developed and incorporated into the member's medical record, along with written progress notes. MaineCare requires that medical records and other pertinent information will be transferred, upon request, to other physicians or clinicians with member's consent.

The plan of care shall include, but is not limited to:

1. Member's presenting problem and diagnosis;
2. Long and short range goals;
3. A description of the service(s) needed by the member to address the goal(s);

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4. An estimate of the frequency and duration of the needed service(s) and support(s);
5. The identification of providers of the needed service(s) and support(s);
6. Plans for coordination of services with other health care providers, as appropriate; and
7. A discharge plan.

The provider must document each service provided, showing the date of service, the type of service performed and its relationship to the plan of care, the length of time of the service, and the signature of the individual performing the service.

Providers must write progress notes regularly that state the progress the member has made toward the long and short-term goals.

**90.08-2 Evaluation and Management (E/M) Services**

Providers should utilize the most recent edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, for definitions of levels and components of Evaluation and Management (E/M) Services.

Medical examinations, evaluations, treatment, and other services are defined by the component and level of service provided. The various components and levels require differing degrees of skill, knowledge, time, effort, and responsibility. The components and levels of service and the member status apply to evaluation and management services provided in the physician's office, the hospital, the member's home, and long-term care facilities. Providers must use appropriate CPT codes to indicate appropriate levels and components of service. Providers must document levels and components of service in the medical record.

**98.08-3 Disclosure Requirements**

Upon request, the physician must furnish to the Department, without additional charge, the medical records, or copies thereof, corresponding to and substantiating services billed by that physician.

**90.08-4 Supplementation**

- A. **Covered Services.** The provider shall accept as payment in full the amounts established by the Department for covered services.

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Therefore, the provider shall not charge a member an amount in addition to the payment received, or to be received, from MaineCare for a covered service. This is a violation of federal and state laws.

In addition, providers may not bill members or other providers for documentation fees or to complete paperwork required for referrals for prior authorization, to document rehabilitation potential, to certify medical necessity of a MaineCare covered service, or to provide other written information required for services covered by MaineCare. Providers must provide copies of such documentation at no charge to members and to relevant providers upon the member's request and upon completion of appropriate consents for release of information.

- B. **Non-covered Services.** The member may be charged for a non-covered service. However, prior to provision of a non-covered service, the provider must clearly explain to the member that he or she will be financially liable for payment for such service. Providers shall document in the member's record that notification of financial liability for non-covered services has been made.

Providers may not bill MaineCare or the member for missed appointments.

Please refer to MBM, Chapter I for policies and procedures applicable to all non-covered and non-reimbursable services. Providers must apply for prior authorization and receive a denial stating that the procedure is non-covered prior to initiating member consent for liability of non-covered services.

The member may voluntarily choose to pay for non-covered services and may be charged for those services, as long as he or she clearly understands prior to provision that he or she will be financially liable for such service. Providers must document the member's informed consent for provision of these non-covered services.

**90.08-5 Procedure to Request Prior Authorization (PA)**

All prior authorization requests should include pertinent information concerning the nature, extent, need, and charge for the procedure or service. Requests should be sent in writing or faxed to:

MaineCare Prior Authorization Unit  
Office of MaineCare Services  
11 State House Station  
Augusta, Maine 04333-0011

Note: Refer to MBM, Chapter I, for policies and procedures regarding prior authorization for out-of-state services.

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**90.08 POLICIES AND PROCEDURES (cont.)**

**90.08-6 Program Integrity (PI)**

All MaineCare services are subject to Program Integrity procedures as described in the MaineCare Benefits Manual, Chapter I.

**90.09 REIMBURSEMENT**

**90.09-1 Fee Schedule**

MaineCare reimburses physicians using a fee schedule known as the MaineCare rate of reimbursement (See Section 90.09-2 A.) The fees or cap associated with service codes are in the MaineCare claims processing database, and are available to any provider who requests a paper or electronic copy. The information is also available on the Office of MaineCare Services website: <http://www.maine.gov/bms/provider.htm>. Fees are subject to change, although the rate in effect as of the date of service applies for procedures performed on that date.

Providers who use electronic information from the website should note that they are still subject to all applicable MaineCare rules. The MaineCare Program will provide quarterly updates on the website.

Providers must bill using their usual and customary charges and reimbursement will be in accordance with the criteria cited below. Providers must bill medical supplies and therapeutic injections at their cost, using NDC codes where available. Providers should direct any questions to the provider relations specialist assigned to their geographic area of practice.

**90.09-2 MaineCare Reimbursement Rate**

MaineCare will reimburse the lowest of the following for covered services:

- A. The MaineCare rates of reimbursement as found in this Section and posted in the fee schedule on the MaineCare website:

MaineCare physician fee schedule rates other than drug prices for new or changed codes (any CPT or HCPCS code) are determined based on the following benchmark:

For services provided on or after July 1, 2008, the fee for service rate is set at 56.94% of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or

- B. The lowest amount allowed by Medicare Part B for Maine area “99” non-facility fee schedule; or

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- C. The provider's usual and customary charges; or
- D. The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set in MBM, Chapter I. MaineCare considers a claim paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

**90.09-3 Reimbursement Rate for Drugs Administered By Other than Oral Methods**

See instructions in Section 90.04-7 for instructions on how to bill for drugs administered by other than oral methods, miscellaneous drugs, inhalation drugs, or chemotherapy drugs. MaineCare determines drug fee schedules for drugs payable under this section by the lower of:

- 1) Ninety five percent (95%) of Average Wholesale Price (AWP); or
- 2) The lowest price that the product or drug can be obtained by the provider.

**90.09-4 Primary Care Provider Incentive Payment**

The Primary Care Physician Incentive Payment (PCPIP) rewards physicians who have provided quality primary care to MaineCare members. Physicians receive scores in various categories such as the number of MaineCare patients, emergency room utilization and prevention/quality. Each physician's practices are compared to other physicians in his/her primary care specialty and then are given an overall ranking. Physicians ranking above the twentieth percentile will receive a monetary share of their specialty pool, based on percentile. The twentieth percentile and below do not receive a monetary share of their specialty pool. The following describes how the incentives are calculated:

- 1. **Access** - Forty Percent (40%)
  - a. Total number of unduplicated MaineCare members served per quarter.
  - b. Total number of health care providers accepting new MaineCare members.
- 2. **Utilization** – Thirty Percent (30%)

Emergency visit and/or hospitalization rate per quarter for physicians unduplicated MaineCare members per quarter.
- 3. **Quality** - Thirty Percent (30%)
  - a. Preventive measures score higher.

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- b. Comparison of quality indicators (QI) among specialty groups.

**Examples:**

**Childhood immunization** - percentage of children in the practice immunized by age two (2) against DPT, polio, measles/ mumps/rubella, type B influenza, and hepatitis B.

**Adolescent immunization** - percentage of adolescents in practice's children who have had following immunizations by age thirteen (13): second dose of measles/mumps/rubella, hepatitis B, tetanus/ diphtheria booster, and chicken pox.

**Prenatal Care** - percentage of women in practice who delivered a baby in previous year and received prenatal care in the first trimester.

**Post-delivery checkup** - percentage of mothers in practice who had a checkup within six (6) weeks after delivery.

**Mammography** - percentage of women in practice ages fifty-two (52) to sixty-nine (69) who had a mammogram in previous year.

**Pap test** - percentage of women in practice ages twenty-one (21) to sixty-four (64) who had a pap test for cervical cancer in previous year.

**Board certification** - percentage of practice board certified in appropriate discipline.

The specific indicators utilized will be selected quarterly as necessary to obtain targeted quality of care evaluations. The same criteria shall be used among similar groups of physicians, i.e., family practitioners/general practitioners, internal medicine, pediatrics, etc.

- 4. **Member Satisfaction** (percent allocation to be determined in second year of physician assessment)
  - a. Percentage of members who change primary physician.
  - b. Percentage of members who report they are completely or very satisfied with their care.

**5. Determination of Physician Incentive Payments**

The elements described above will be the basis for placing each participating MaineCare physician in an octal grouping as follows:

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**90.09 REIMBURSEMENT (cont.)**

**Group 1 Percentile- Sixty Percent (60%) Of Total Payment**

Octal 1	90 - 100	Thirty percent (30%) of Group 1 payment
Octal 2	80 - 89	Twenty percent (20%) of Group 1 payment
Octal 3	70 - 79	Ten percent (10%) of Group 1 payment

**Group 2 Percentile - Twenty-Five Percent (25%) Of Total Payment**

Octal 4	60 - 69	Ten percent (10%) of Group 2 payment
Octal 5	50 - 59	Eight percent (8%) of Group 2 payment
Octal 6	40 - 49	Seven percent (7%) of Group 2 payment

**Group 3 Percentile - Fifteen Percent (15%) Of Total Payment**

Octal 7	30 - 39	Ten percent (10%) of Group 3 payment
Octal 8	20 - 29	Five percent (5%) of Group 3 payment

No Payment for 0 - 19 Percentile

**90.10 BILLING INSTRUCTIONS**

Providers must bill in accordance with the Department's billing requirements for the CMS 1500 specific to Physician Services.

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**Appendix A**

**90A-01 COVERED ORGAN TRANSPLANT PROCEDURES**

MaineCare reimburses for services related to organ transplants only when all criteria of this section are met, and a Department-approved transplant center recommends that the transplant be performed. MaineCare does not cover transplants that are considered experimental or investigational in nature.

MaineCare covers procedures (evaluations and transplants) that include, but are not limited to: heart, heart-lung, bone marrow (autologous and allogeneic bone marrow or stem cell transplants), kidney, corneal, liver, lung, small intestine, combined liver-small intestine, and pancreas transplants.

**90A-02 NON-COVERED TRANSPLANT SERVICES**

MaineCare will not cover evaluations for transplant or transplants if any of the following apply:

- a. Another procedure of lower cost and of less risk may achieve the same or similar result; or
- b. The transplant is not expected to make a significant difference in the member's health and/or performing the transplant will serve primarily an academic purpose; or
- c. The transplant is contraindicated by the medical condition, age, and prognosis of the member; or
- d. The transplant center and/or the member's specialist do not recommend that the evaluation for transplant or transplant be performed.

**90A-03 TRANSPLANTS NOT REQUIRING PRIOR AUTHORIZATION**

- a. In-State Transplant Procedures Not Requiring Prior Authorization

The following transplant procedures and evaluations do not require prior authorization, as long as they are performed in the State of Maine:

- 1) Kidney Transplants. Title XVIII of the Social Security Act of the Medicare program reimburses for kidney transplants for members with end stage renal disease. For members who are dually eligible for both Medicare and MaineCare, MaineCare will reimburse for only Medicare coinsurance and deductible costs customarily reimbursed by MaineCare.
- 2) Corneal Transplants. MaineCare covers corneal transplantation to correct corneal opacity or keratoconus.

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**90A-03 TRANSPLANTS NOT REQUIRING PRIOR AUTHORIZATION (cont.)**

- 3) Autologous or Allogeneic Bone Marrow or Stem Cell Transplants. MaineCare covers bone marrow or stem cell transplants. MaineCare covers these procedures when used to replace bone marrow damaged by high doses of radiation therapy or chemotherapy.

**90A-04 TRANSPLANTS REQUIRING PRIOR AUTHORIZATION**

All transplants and transplant evaluations performed outside the State of Maine require prior authorization, as described in MBM, Chapter I. All transplants and transplant evaluations require prior authorization unless the transplant meets the criteria of 90A-03 above:

a. Transplant Procedures Requiring Prior Authorization

MaineCare will consider prior authorization for organ transplants when all of the following criteria are met:

- 1) Both the transplant center and the member's in-state specialist recommend that the transplant be authorized after the member is evaluated; and
- 2) The transplant meets all other criteria specified in Section 90 and this Appendix; and
- 3) MaineCare has received complete documentation from the transplant center to make a determination.

b. Overview of the Authorization Process

The provider must submit complete documentation and all criteria listed in this section must be met before MaineCare will consider requests for prior authorizations for evaluations and transplant services. In making a determination, MaineCare will utilize appropriate staff including but not limited to Office of MaineCare Services medical consultants, a medical specialist in the relevant field of the requested transplant (e.g. cardiologist for heart transplants), a psychiatrist or psychologist and designee(s) of the Director of the Office of MaineCare Services. MaineCare prior authorization staff will review the materials and make a determination by considering established patient selection and facility criteria within this section. To make its decision, the Department will also look for evidence that the request conforms to general and organ specific patient selection criteria, and recommendations of relevant medical specialists.

The Department will notify the requesting physician, other appropriate providers, and the member of the decision whether an evaluation or transplant is prior authorized within thirty (30) days of the request. Members may appeal decisions based on information in the MaineCare Benefits Manual, Chapter I, General Administrative Policies and Procedures.

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**90A-04 PRIOR AUTHORIZATION (cont.)**

1. Documentation for Prior Authorization

The Department will make a decision regarding prior authorization for the transplant procedure after reviewing the transplant center's report submitted to the MaineCare Prior Authorization Unit. The report must include written assessments performed by the appropriate specialists and recommendations regarding all possible treatment options. The report must also include the specialists' general assessment of the member's anticipated prognosis and the risks and benefits (e.g. quality of life) associated with each potential treatment option, including transplant.

Providers must clearly document all of the following information concerning the member's health in the written report:

- i. Diagnosis;
- ii. Pertinent medical history;
- iii. Alternate treatments performed and their results;
- iv. Recommended transplant procedure;
- v. Expected prognosis after recommended treatment;
- vi. Second opinion of the member's condition from a board-certified specialist affiliated with a tertiary care hospital. This assessment must be based upon a review of the member's medical records and previous diagnostic studies and must provide recommendations regarding all possible treatment options for the member. Based upon the consultant's experience with similar cases, the report must also include the consultant's general assessment of the member's prognosis and of the risks and benefits (i.e., quality of life) associated with each potential treatment option, including transplant; and
- vii. A report of an assessment by a mental health professional for members age nineteen (19) and older who are being assessed for transplants other than a bone marrow transplant. The assessment must address the member's mental health and ability to understand both the procedure and its psychological aftermath. This report shall include comments on the member's ability to take medications and comply with medical recommendations and on the member's family or other support system's ability to assist the member in coping with both the procedure and its psychological aftermath. The professional must state that the member is currently (in the prior four (4) weeks) not abusing drugs or alcohol and

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**90A-04 PRIOR AUTHORIZATION (cont.)**

has agreed to any on-going counseling recommended regarding drug or alcohol abuse.

- viii. A written medical record release signed by the member or the member's guardian.

MaineCare prior authorization staff may require additional information to make a determination.

Providers must submit the request for prior authorization for transplant evaluations and transplant services to:

MaineCare Prior Authorization Unit  
Office of MaineCare Services  
11 State House Station  
Augusta, Maine 04333-0011

2. **Duration of Prior Authorization**

Any prior authorization for reimbursement for an organ transplant procedure shall expire one (1) year after the date of prior authorization. If the transplant procedure has not been performed within that period, then prior authorization must once again be sought for the member.

Providers must repeat the prior authorization process for re-authorization. This second review will focus on reassessing the member's condition and updating the information submitted for the initial authorization. MaineCare will utilize this information to make the appropriate final decision regarding re-authorization for an evaluation and approval or denial of coverage for the transplant.

3. **Patient Selection Criteria**

a. **General Selection Criteria:**

Members must meet all of the following general criteria before MaineCare grants prior authorization of the evaluation and/or the transplant:

1. The member's overall physiological condition must indicate a reasonable expectation for success; and

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**90A-04 PRIOR AUTHORIZATION (cont.)**

2. Alternative medical therapies have been tried and have failed or, if tried, would not prevent progressive disability or death; and
3. There is every reasonable expectation that the member will strictly adhere to the difficult long-term medical regimen required; and
4. The member is emotionally stable and has a realistic attitude toward illness; and
5. Current history (current and for at least four (4) weeks preceding the transplant evaluation and actual transplant) is free of alcohol or drug abuse; and
6. There is a reasonable likelihood that the transplant will extend the member's life expectancy at least two (2) years and to restore a range of physical and social functions of daily living; and
7. The member meets all established criteria and presents no contraindications set by the approved transplant center for the specific transplant procedure; and
8. The member has been evaluated by a transplant facility approved by the Department and the transplant center has recommended the transplant and indicated a willingness to perform the procedure.

**b. Specific Selection Criteria:**

In addition to the general selection criteria stated above, each member must meet all transplant center specific criteria for each transplant. These criteria are set by the transplant center and include indications and contraindications for specific organ transplant procedures based on national standards. The Department will not prior authorize any transplant if the transplant center does not approve the procedure based on all specific selection criteria set by the transplant center.

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**90A-05 CRITERIA FOR SELECTION OF TRANSPLANT CENTERS**

MaineCare will only cover transplants performed in Department-approved transplant centers.

While physicians may request specific transplant centers, the Department reserves the right to select the transplant center a specific transplant is approved for. Whenever possible, the Department will approve the physician's request for the site of the member's organ transplant evaluation. If several Department-approved transplant centers are available for specific transplants, the Department reserves the right to authorize the transplant in the most cost-effective transplant center. When all other factors are equal, the Department will give preference to the provision of services at an in-state or regional transplant center in order to enhance continuity of care by minimizing the distance that the member and family will have to travel for evaluation, the transplant procedure, and after-care.

- a. Initial Approval of Out-of-State Transplant Centers (Not required for existing kidney transplant facilities or for any corneal or bone marrow transplant facility):

To approve the use of an out-of-state transplant center facilities must have the following:

1. Initial approval of an out-of-state transplant center requires documentation of a survival rate for the relevant transplant procedure comparable with the national experience. This survival rate must be based on a sufficient number of procedures (e.g. twelve (12) procedures over the past twelve (12) months) to enable the Department to compare the new transplant center with other national transplant centers that are performing the procedure.

- b. On-going Approval of Out-of-State Transplant Centers:

The Department will approve out-of state transplant center facilities on a continuing basis using the following criteria:

1. The transplant center has personnel experienced with the relevant specialized surgeries, infectious diseases, pediatrics, pathology, pharmacology, anesthesiology, tissue typing, immunological and immunosuppressive techniques and blood bank support services; and
2. The center has a consistent, equitable, and practical protocol for selection of candidates and, at a minimum, must adhere to the Department's General Patient Selection Criteria; and
3. The center has adequate services to provide emotional and social support for members and their families; and
4. The center has satisfactory arrangements for donor procurement services; and

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**90A-05            CRITERIA FOR SELECTION OF TRANSPLANT CENTERS (cont.)**

5.        The center has demonstrated willingness and the ability to provide relevant information to the member's physicians, to MaineCare staff, and to other transplantation center personnel; and
6.        The transplant center maintains all required federal, state, or provincial accreditations and certifications; and
7.        The transplant center is a Medicare approved transplant center for all applicable transplants, including heart, lung, heart-lung, liver, and intestinal transplant centers; and
8.        The transplant center maintains conformance to the national survival rate criteria as described in (a) above; and

The transplant center must maintain continuing approval dependent upon meeting all above criteria. The transplant center must report any changes in status regarding meeting the above criteria to the Department.

**c.            Initial Approval for In-State Transplant Centers**

The Department will waive conformance to the national survival rate criteria described in (a) above for any new in-state transplant centers for a two (2) year period. All other criteria described above must be met. This two (2) year start-up period, which will begin with the first transplant procedure performed in the in-state facility, is designed to enable the in-state transplant center to secure sufficient experience to obtain a survival rate that can be compared with national experience.

**d.            Continued Approval for In-State Transplant Centers**

Continued approval for the in-State center after this two (2) year start-up period requires evidence of a survival rate that is comparable with the national experience and of success with and safety of the transplant procedure. The Department must be able to base this survival rate on a sufficient number of procedures to enable the Department to compare the in-state transplant center with other national transplant centers that are performing the procedure. The in-state transplant center must meet all other criteria described in (b) above in order to receive continued transplant center approval. The transplant center must report any changes in status regarding meeting the above criteria to the Department.

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**90.01 REIMBURSEMENT**

See the rates listed by procedure code on the OMS website, at [www.maine.gov/bms](http://www.maine.gov/bms).

**90.02 REIMBURSEMENT CODING**

**90.02-1 Common Procedure System and Codes**

Approximately once a year the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, issue a Healthcare Common Procedure Coding System (HCPCS) transaction list to participating states that includes additions to and deletions from the current schedule of codes. Providers must consult the most recent version of the Current Procedural Terminology (CPT) and HealthCare Financing Common Procedure Coding System (HCPCS) code book(s) for correct billing codes. In those few instances where the CPT and HCPCS code book do not address the needs of the provider, the provider must consult his/her MaineCare Provider Relations Specialist for the appropriate MaineCare-specific code, also called a “local code”, if it is not listed in this Section. Providers may also find codes available on the Bureau of Medical Services website at: [www.maine.gov/bms](http://www.maine.gov/bms).

**A. Level I Codes (CPT)**

Providers should use the most recently published edition of the Current Procedural Terminology (CPT), as developed by the American Medical Association. These are five-digit numeric codes and descriptive terms used for reporting medical services and procedures. CPT codes also include two-digit numeric modifiers.

**B. Level II Codes (HCPCS)**

These are five-digit alphanumeric codes, and their descriptions were developed by CMS for use in defining physician and non-physician services that are not addressed in the CPT coding system.

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**90.02 REIMBURSEMENT CODING (cont.)**

(1) Tobacco Cessation Counseling

	Code	Tobacco Cessation Counseling	MaineCare Rate
Eff. 3/29/09	99402	This code may be used alone if the only service provided is tobacco cessation counseling or in addition to appropriate E & M code.  Codes that will be paid in addition to 99402 are:	See Fee Schedule
	99201- 99205	New Patient Office Visit	See Fee Schedule
	99211- 99215	Established Patient Office Visit	See Fee Schedule
	99383- 99387	New Patient Preventive Care	See Fee Schedule
	99393- 99397	Established Patient Preventive Care	See Fee Schedule

C. Level III Codes (Local Codes)

The Office of MaineCare uses the following codes for those services not identified in CPT or HCPCS codes:

(1) Pediatric Dental Anesthesia

Code	Pediatric Dental Anesthesia Description	Rate
ZPD1	Pediatric Dental General Anesthesia (first 30 minutes)	\$150.00
ZPD2	Pediatric Dental General Anesthesia (additional 15 minute increment)	\$50.00

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**90.03 MODIFIERS**

A modifier is a two-character code added as a suffix to the CPT procedure code. A modifier provides the means by which a provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code. Providers should use modifiers in situations such as:

1. A procedure that has both a professional and technical component;
2. A procedure was performed by more than one physician;
3. A bilateral procedure was performed; or
4. Unusual events occurred.

Providers should use two-character modifiers listed in the most recent CPT guidelines. Providers should note that while CPT guidelines allow for the use of a five digit numeric modifier in addition to the procedure code, MaineCare only accepts and processes two-character modifiers.

As with the procedure codes, there are three types of modifiers: CPT modifiers, which are numerical; HCPCS modifiers, which are alphabetical; and local modifiers, which are also alphabetical. Modifiers can be used interchangeably with all codes; for example, CPT modifiers can be used with HCPCS codes, etc. Some modifiers are meant to affect the fee for a particular service. These are called pricing modifiers. For example, the modifier used to indicate a surgical assist will allow payment of a percentage of the fee paid to the primary surgeon.

Some modifiers do not affect the pricing of a particular code, but they do describe more accurately the service provided. These are called descriptive modifiers. For example, there is a modifier that identifies a service as concurrent care. This modifier more accurately defines the service, but does not affect the level of reimbursement for the service.

Providers must accurately describe a service by using the appropriate code and up to two modifiers. Where this is not possible, providers should use a modifier code "99" to indicate multiple modifiers. The use of modifier "99" will result in manual review of a claim and delayed payment. Therefore, providers should reserve the use of modifier "99" for those situations in which a service can be properly reimbursed only by the use of three or more modifiers.

The following examples illustrate the proper use of modifiers:

Example 1 - Billing for surgical assist at radical mastectomy =

Code		Modifier	
19200	+	80	(fee will be affected)

Example 2 - Surgical assist of cholecystectomy and repair of femoral hernia =

Primary Procedure		Modifier	
Code		Surgical assist	
47600	+	80	

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**SECTION 90**

**ALLOWANCES FOR PHYSICIAN SERVICES**

**1/1/98**

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**90.03 MODIFIERS (cont.)**

Secondary Procedure Code 49220 +	Modifier Multiple Procedures 51	+	Modifier Surgical assist 80 (fee will be affected)
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Example 3 - Arthroplasty, knee, total; radical, left side =

Procedure Code 27444	+	Modifier left side LT	(fee will not be affected)
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**90.03-1 Pricing Modifiers**

Modifier	Source	Definition
PC	Local	Technical Component- radiology only (TC also acceptable)
PB	Local	Both Professional & Technical components- radiology only
QZ	Local	Anesthesia by a Registered Nurse- Used when the Registered Nurse provides regional or general anesthesia. Providers should not use this modifier to indicate the use of local anesthesia.

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SECTION 55

LABORATORY SERVICES

7/15/79

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55.05 **POLICIES AND PROCEDURES**

- B. The Department and its professional advisors regard the maintenance of adequate client records as essential for the delivery of quality care. In addition, providers should be aware that these records are key documents in conducting post payment reviews. In the absence of proper and complete client records, no payment will be made and payments previously made may be recovered in accordance with Chapter I, of the MaineCare Benefits Manual.
- C. The Department requires that client records and other pertinent information will be transferred, upon request and with the client's signed release of information, to other providers involved in the client's care.
- D. Upon request, the provider will furnish to the Department, without additional charge, the clinical records, or copies thereof, corresponding to and substantiating services billed by that provider.

55.06 **CONFIDENTIALITY**

The disclosure of information regarding individuals participating in the Medicaid program is strictly limited to purposes directly connected with the administration of the Medicaid program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431 et seq. and other applicable sections of state and federal law and regulation.

55.07 **REIMBURSEMENT**

The MaineCare rates are posted in the fee schedule on the MaineCare website. Rates other than drug prices for new or changed codes (any CPT or HCPCS code) are determined based on the following lowest benchmark:

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- A. The fee for service rate is set at fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or
- B. The lowest amount allowed by Medicare Part B for Maine area "99" non-facility fee schedule; or
- C. The provider's usual and customary charge.

In accordance with Chapter I, of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other source that is available for payment of a rendered service prior to billing the Office of MaineCare.

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**SECTION 75**

**VISION SERVICES**

**11/01/04**

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**75.06 CO-PAYMENT (cont.)**

MaineCare Payment for Services	Member Co-payment (Optometrist)	Member Co-payment (Optician)
\$10.00 or less	\$ .50	\$ .50
\$10.01 - 25.00	\$1.00	\$1.00
\$25.01 - 50.00	\$2.00	\$2.00
\$50.01 or more	\$3.00	\$3.00

**75.06-2 Member Responsibility**

Co-payment for members may not exceed \$2.00 per day or \$20.00 per month for services provided by an optician or \$3.00 per day or \$30.00 per month for services provided by an optometrist. After the cap has been reached, the member will not be required to make additional co-payments and the provider will receive full MaineCare reimbursement for covered services.

**75.07 REIMBURSEMENT & BILLING**

**75.07-1 Reimbursement**

The provider must accept as payment in full the amounts established by MaineCare for covered services. Therefore, in accordance with State and federal laws, providers cannot charge a member an amount in addition to the payment received, or to be received, from MaineCare for a covered service.

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The MaineCare rates of reimbursement are posted in the fee schedule on the MaineCare website. Rates other than drug prices for new or changed codes (any CPT or HCPCS code) are determined based on the following lowest benchmark:

- A. The fee for service rate is set at fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or
- B. The lowest amount allowed by Medicare Part B for Maine area "99" non-facility fee schedule; or
- C. The provider's usual and customary charge.

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**SECTION 95**

**PODIATRIC SERVICES**

**7/01/79**

**Last Updated: 3/29/09**

**95.06 POLICIES AND PROCEDURES**

**95.06-1 Member Records**

The Department requires a specific record for each member, that includes, but is not necessarily limited to:

- A. the member's name, address, and birthdate;
- B. the member's history, as appropriate;
- C. findings from the physical examination;
- D. long and short range goals, as appropriate;
- E. any tests ordered/performed and the results;
- F. treatment or follow-up care;
- G. any medications and/or supplies dispensed or prescribed;
- H. recommendations for additional treatments and sources of care;
- I. the dates on which all services were provided; and
- J. written progress notes that identifies the services provided.

Entries are required for each date of service billed and must include the podiatrist's name and signature.

**95.06-2 Program Integrity Unit**

The Program Integrity Unit requirements apply as defined in the MaineCare Benefits Manual, Chapter I, General Administrative Policies and Procedures.

**95.07 REIMBURSEMENT**

- A The MaineCare rates of reimbursement are posted in the fee schedule on the MaineCare website. The fee for service rate is set at fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time if lower than the following or otherwise, the lowest of:

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**SECTION 95**

**PODIATRIC SERVICES**

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**95.07 REIMBURSEMENT (cont)**

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1. The lowest amount allowed by Medicare Part B for Maine area “99” non-facility fee schedule; or
2. The usual and customary charges.
3. The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set in Chapter I of the MaineCare Benefits Manual. MaineCare considers a claim paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

- B. In accordance with Chapter I, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, worker's compensation, etc.) that are available for payment of the rendered service, and to bill that potential payor prior to billing MaineCare.

**95.08 COPAYMENT**

**95.08-1 Copayment Amount**

- A. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed \$2.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$ .50
\$10.01 - 25.00	\$1.00
\$25.01 or more	\$2.00

- B. The member shall be responsible for copayments up to \$20.00 per month whether the copayment has been paid or not. After the \$20.00 cap has been reached, the member will not be required to make additional copayments and the provider will receive full MaineCare reimbursement for covered services.

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**SECTION 101**

**MEDICAL IMAGING SERVICES**

**12/12/94**

**Last Updated: 3/29/09**

**101.06 POLICIES AND PROCEDURES (cont.)**

- b. performing diagnostic, therapeutic, or screening procedures personally;  
and
- 2. if necessary, checking radiographs or checking preliminary readings in  
radioisotope studies; and
- 3. studying and evaluating results of diagnostic or therapeutic procedures,  
interpreting radiographs or radioisotope data, or estimating results of treatment;  
and
- 4. dictating report of examination or treatment; and
- 5. consulting with the referring physician regarding the results of the diagnostic or  
therapeutic procedures.

The professional component as a separate service is a covered service only when provided by a qualified physician.

The administrative and technical components include services associated with technologists, clerical staff, films, opaques, radioactive materials, chemicals, drugs or other materials, purchase, rental use or maintenance of space, equipment, telephone service or other facilities or supplies.

**101.06-2 The Division of Program Integrity**

See the MaineCare Benefits Manual (MBM), Chapter I for the Division of Program Integrity procedures.

**101.07 REIMBURSEMENT**

**101.07-1** The MaineCare rates of reimbursement are posted in the fee schedule on the MaineCare website. Rates other than drug prices for new or changed codes (any CPT or HCPCS code) are determined based on the following lowest benchmark:

Eff.3/29/09

- A. The fee for service rate is set at fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or
- B. the lowest amount allowed by the Medicare Part B carrier; or
- C. the provider's usual and customary charge.